ImagiNation LEARNING CENTER

AUTHORIZATION FOR MEDICATION

FAX TO: (703)817-1534 OR (703)817-1535

This form must be filled out completely and accurately for **each medication** prescribed by your physician or the medication will not be administered to your child.

Reminder: non-prescription medication will not be administered to your child without written instructions from the physician.

I hereby authorize ImagiNation Learning Center to administer the following medication to my child, _____.
(Name of Child)

PRESCRIPTION/NON-PRESCRIPTION (Circle One)	
Medication Name:	Dosage Amount:
Time(s) to be given:	
Medication Authorized from _____ to _____*	
*Long term medications such as those for asthma & allergies may be authorized for a one-year period. **All others are for a ten-day period ONLY.**	Side Effects?:

_____ _____
Parent's Signature Date

_____ _____
Doctor's Signature Date

Doctor's Office Stamp

For Office Use Only:

- ☐ Medication accepted by: _____.
- ☐ Date accepted: _____.
- ☐ Medication Name: _____.
- ☐ Name on Prescription: _____.
- ☐ Dosage on Prescription: _____.
- ☐ Physician Name: _____.
- ☐ Expiration on Medication: _____. (Expired medication will not be accepted)
- ☐ Medication in Original Container? _____. (If not, medication will not be accepted)